

# Partnerships for People With Serious Mental Illness Who Live Below the Poverty Line

Hugh G. Lafave, M.D.  
Henry R. de Souza, M.S.W.  
Pamela N. Prince, M.A.  
Kathleen E. D. Atchison  
Gary J. Gerber, Ph.D.

*Fifty-four persons with serious mental illness who were living below the poverty line were randomly divided into two groups. Members of one group received allowances and forgivable loans to raise them above the poverty line for one year. The others received some funds, but not enough to raise them above the poverty line. All participants selected one staff member from a consortium of supporting agencies to serve as a sponsor and another person to serve as an adviser to help them function better. For both*

*groups hospitalization rates were significantly reduced, and quality of life in some domains improved. (Psychiatric Services 1071-1073, 1995)*

Powerlessness, poverty, and poor health are intractably linked. Many reports have attested to the association between poor mental and physical health, poverty, and social environment (1-4). Because of a combination of factors such as suboptimal psychiatric services, inadequate social supports, and limited housing options, persons with serious mental illness confront life stresses far in excess of those produced by illness alone (5).

Paradoxically, psychiatry has generally responded to mental illness by providing expensive services rather than addressing fundamental issues such as poverty. In Ontario, for example, heavy users of psychiatric services (6) receive inpatient services at costs exceeding \$6,000 (Canadian) per person per month; however, at discharge, they receive a maximum family benefits allowance of only \$886 per month. This benefit level places them below the poverty line of \$975 (Canadian) per month for a single person (7). Moreover, clients who are heavy users do not receive services responsive to the needs they articulate or sufficient to prevent unnecessary hospital admissions (8).

A major impediment to successful programs for persons with serious mental illness has been the failure of program planners to engage consumers in the program development process (9). In the development phase of the project described below, extensive consultations with consumers were undertaken. Focus groups of heavy users identified poverty and the inability to influence service delivery as the biggest obstacles they

Dr. Lafave was formerly director of rehabilitation services for Eastern Ontario at Brockville Psychiatric Hospital in Brockville, Ontario, and clinical associate professor in the department of psychiatry at the University of Ottawa. Dr. Gerber is director of research and Mr. de Souza is manager of the assertive community rehabilitation program at Brockville Psychiatric Hospital. Dr. Gerber is also clinical assistant professor in the departments of psychiatry and psychology at the University of Ottawa, where Ms. Atchison was formerly in the research department. Ms. Prince is the research coordinator at Brockville Psychiatric Hospital and a doctoral candidate in the department of psychology at Carleton University in Ottawa. Send correspondence to Dr. Gerber at Brockville Psychiatric Hospital, P.O. Box 1050, Brockville, Ontario, Canada K6V 5W7.

**Table 1**

Mean scores on the Quality of Life Interview of persons with serious mental illness who received funds to raise their income above the poverty level (study group) and those who did not (comparison group), at three points in a one-year study<sup>1</sup>

Domain	Study group (N=26)			Comparison group (N=22)		
	Initial	Mid-point	Final	Initial	Mid-point	Final
Objective						
Living situation	.79	.79	.85	.84	.84	.80
Recreation	.55	.56	.52	.50	.54	.51
Family relations	.63	.58	.62	.60	.63	.63
Social relations	.54	.50	.65	.61	.56	.63
Finances <sup>2</sup>	.56	.63	.64	.53	.56	.63
Legal and safety	.90	.93	.93	.93	.94	.92
Physical and mental health <sup>3</sup>	.65	.74	.75	.65	.69	.70
Subjective						
Living situation	5.23	5.45	5.40	4.92	5.08	5.25
Daily activities	4.45	5.05	4.93	4.83	4.77	5.09
Family relations	4.28	4.47	4.55	4.44	4.68	4.61
Social relations	4.74	5.01	4.73	4.87	4.64	5.01
Finances <sup>4</sup>	3.28	4.70	4.54	3.44	4.07	4.21
Work and school	5.67	4.44	4.01	5.58	5.33	4.92
Legal and safety	5.02	5.28	5.24	4.47	4.48	4.52
Physical and mental health	4.58	4.86	5.07	4.57	4.91	4.87
Global	3.94	4.56	4.23	4.25	4.25	4.63

<sup>1</sup> Scaled objective domain scores range from 0 to 1; the higher the score, the more favorable the quality-of-life domain. Subjective domain scores are based on Lehman's 7-point scale (from 1, terrible, to 7, delighted). Differences in degrees of freedom for significant comparisons reflect the fact that some subjects did not answer enough questions to permit construction of a domain score.

<sup>2</sup>  $F=3.43$ ,  $df=2,70$ ,  $p<.05$ , for changes in both groups' scores

<sup>3</sup>  $F=5.40$ ,  $df=2,88$ ,  $p<.01$ , for changes in both groups' scores

<sup>4</sup>  $F=8.99$ ,  $df=2,80$ ,  $p<.01$ , for changes in both groups' scores

faced, outweighing all other concerns.

The aim of this study was to examine whether increasing consumer participation in and influence on mental health services would affect the rate of hospital readmissions and whether raising the income of heavy service users above the poverty line would affect their quality of life.

## Methods

Eleven agencies serving persons with severe and persistent mental illness in two counties in Eastern Ontario organized a consortium to provide more responsive services to heavy users of services. The agencies nominated clients who were heavy service users and who lived below the poverty line to participate in the one-year study.

A total of 54 of the nominees agreed to participate. During the previous three years, all participants

had three or more inpatient psychiatric admissions or had been hospitalized for 90 days or more in a psychiatric facility.

Each of the 54 participants hand-picked one sponsor from among consortium agency staff members; each also selected a family member, peer, or volunteer to serve as an adviser. Representatives of the consortium agencies met monthly or at the request of participants to better coordinate services. Sponsors and advisers met with participants regularly to advocate with them for better coordination of mental health services and to help them become more functional in their communities. Topics reviewed with participants included problem solving in a variety of areas, such as finances and budgeting, recreational and vocational opportunities, and interpersonal relationships.

To examine the impact of raising the income of heavy users above the

poverty line, the 54 participants were randomly divided into study and comparison groups. Study group participants received \$160 (all amounts are in Canadian dollars) a month and forgivable loans totaling \$1,800 for the study period. This funding maintained study group participants above the poverty line for one year.

Comparison group participants received \$115 for completing three interviews and \$25 to \$35 per month in increasing increments for 11 months to maintain contact with the project and their sponsors and advisers. These payments did not bring comparison group participants above the poverty line.

Statistical analysis showed no differences between study and comparison group participants who completed the study in age, duration of previous hospitalization (Mann-Whitney U test), gender, marital status, education, and diagnosis (chi square test). Six participants withdrew from the project for a variety of reasons, including the stress of having additional funds, hospitalization, religious conflicts, and relocation.

To measure the project's effects on hospitalization, the number of hospital admissions and inpatient days for three years before project entry and for one year after were compared. Savings in hospitalization costs attributable to the project were also estimated.

To measure quality of life, participants were interviewed immediately before entry (initial interview), six months after receiving the first payment (midpoint), and 11 months after the start of the project (final). The Quality of Life Interview (QOLI) (10) was administered to assess changes in participants' life domains during the project. Objective QOLI responses were scored, and scores were combined to form domain scores expressed on a scale of 0 to 1, with higher scores being more favorable. Subjective QOLI responses were obtained on a 7-point scale, from 1, terrible, to 7, delighted, and scores were also combined to form domain scores. The scale has established reliability and validity that have been examined in detail previously (10).

## Results

The number of hospitalization days for all participants decreased by more than 70 percent during the project ( $t=5.67$ ,  $df=47$ ,  $p<.001$ ). This change represents a decrease in the average cost of hospitalization from \$47,300 a year for each participant before the study to an average cost of \$13,500 a year during the study.

A post hoc repeated-measures analysis of variance (ANOVA) revealed no significant differences between the study and comparison groups in the mean annual number of hospitalization days per participant for the three years before the study (154 and 138 days, respectively) and for the study period (47 and 38 days, respectively).

No significant differences in QOLI scores were found between the study and comparison groups at the initial, midpoint, or final interviews. Thus providing additional funds to the study group did not improve their quality of life over that of the comparison group. As shown in Table 1, separate repeated-measures ANOVAs showed improvements over time for both groups in the objective domains of finances and mental and physical health. Among the subjective quality of life domains, finances showed improvement over time for both groups.

## Discussion and conclusions

People with serious mental illness living in the community face perennial problems. Many do not receive coordinated individualized services responsive to their needs, and they often live below the poverty line. This project demonstrated that true partnerships between clients, their peers, volunteers, and mental health agencies can contribute to a significant reduction in hospitalization, particularly when clients have a voice in service delivery through the mechanism of a consortium.

The second aspect of this study attempted to address the poverty faced by most people with serious mental illness living in the community. Providing funds to bring half the participants above the poverty line did not differentially affect their objective or subjective quality of life.

Several explanations for this finding can be offered. First, quality-of-life measures indicated improvement in three areas for both groups over the course of the project. In particular, both groups showed improvement on objective and subjective measures of financial well-being. The support provided by the regular meetings between all participants and their chosen sponsors and advisers may have obscured the impact of bringing half of the participants above the poverty line. The meetings focused on coping with the challenges of daily life as well as budgeting for daily needs; thus scores may reflect participants' improved perception of control over their financial affairs.

Second, because both groups received some money, albeit disproportionate amounts, all study participants may have experienced a very real, if relative, improvement in their financial situation. Third, the funds provided to the study group members may have been insufficient to produce group differences over a limited time period. Finally, the QOLI scale may be inadequate to detect subtle changes in the way clients perceive their life situations.

It appears that partnerships between clients and their sponsors and advisers can be an effective means of improving some aspects of clients' lives, while at the same time dramatically reducing their dependence on hospitalization.

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